University Archives

A Quarterly Tabloid of the Faculty of Medicine at the University of Toronto

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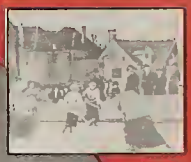
tablet

Tablet Issue!



First Women in Medicine

"It was 1874 when the first women students slipped into the all-male Toronto School of Medicine. In the 110 years that have passed since then, Canadian women have earned a firmly established place in medicine ... but not without a struggle.

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from the dean

Towards Better Communication

I commend to you the TABLET, the first issue of our new Faculty tabloid which both pressure and relief it should have been prescribed and available to us long ago.

There is a strong need for improved communication through out the University. Recent Senate Commission Report, a number of Council Committee reports, and Committee of Presidents have all pointed to the need for improved communication. For example, an investigator hired in the Medical Sciences Building finds learns at a European conference

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continued from cover
"Towards Better Communication"

from the dean

about exciting work at a teaching hospital a few hundred yards from his laboratory. A medical student marveling at recent advances in a major frontier area does not know that one of our department chairmen and some other faculty colleagues are internationally recognized contributors to the field. A resident who came to us after receiving his M.D. degree at another university knows almost nothing about this Faculty except for the hospital in which he is completing his specialty training. A physiotherapy student knows that she is a member of one of Canada's premier medical faculties but has difficulty feeling a part of it.

These examples of inadequate information and communication could be multiplied readily. The need for a Faculty tabloid has led to several versions over the years but these were short-lived. The establishment of an effective Faculty-wide tabloid was among the recommendations of the 1983 joint review by the U.S. Liaison Committee on Medical Education and the Council of Accreditation of Canadian Medical Schools which was generally highly favourable to us. Our response is TABLET which is to appear quarterly. It is directed to the entire University of Toronto "medical family" — its 1,000 medical students, 300 undergraduate students in allied health professions, 1,750 interns and residents, 800 graduate students, and some 3,000 full time, part time and volunteer teachers spread over five university buildings, eleven fully affiliated hospitals and several partially affiliated hospitals, teaching practices and public health units, and members of six graduates' societies.

TABLET will focus on items that will be of interest to the entire "family". It will, of course, supplement and not replace the various departmental and hospital publications, the *Medical Graduate* published by the Medical Alumni Association, or the two current publications of the Faculty — *Health News* (a digest of health information for the intelligent layperson) and *MedEd News* (which focuses on medical under graduate education developments). TABLET will feature information on staff changes, important University events and policies that affect us, developments in our teaching hospitals (notably advances and achievements), profiles of some of our teachers, students and graduates, and the like.

Last year, in my *Mid-Term Report* which many of you will have seen, I summarized the recent history of the Faculty of Medicine and its current status. Since that report was presented to Faculty Council in March there have been some notable developments.

On July 1, 1984 a new Department of Immunology was established under the chairmanship of Dr. Richard Miller. Dr. Miller, a widely recognized scientist at the Ontario Cancer Institute — Princess Margaret Hospital already held the rank of Professor in the Department of Medical Biophysics. It will be his task to assist our immunologists, clustered at the OCI, the Hospital for Sick Children, the Medical Sciences Building, and in several clinical departments, to pool their efforts to advance a discipline which has already taken giant steps forward in understanding how the body's defences against foreign material are mobilized and function. The clinical implications with respect to cancer, autoimmune diseases, and organ transplantation are high on the priority list.

As well, this past summer, Dr. William Tatton assumed the title of Associate Dean, Neuroscience Development for a period of three years. Dr. Tatton, who is also Vice President-Research at the Toronto Western Hospital and holds Professorships in the Departments of Physiology, Medicine and Surgery, will stimulate and coordinate scientific development "from bench to bedside" in the neurosciences. Major neuroscience concentrations will be developed at the Toronto Western Hospital and the Medical Sciences Building, and other foci of research and teaching elsewhere in the Health Science Complex will be strengthened. In the neurosciences, as in immunology, we already have a substantial number of excellent investigators, clinicians and teachers, and the new administrative arrangements are intended to create a more favourable climate for their work.

Elsewhere in this issue of TABLET there are comments on forthcoming developments in oncology and the anticipated acquisition of two major new technologies: more sophisticated Magnetic Resonance Imaging and Extracorporeal Lithotripsy. These will be examined more extensively in future issues.

I look forward to using the

Dean's corner in TABLET to speak to those members of the University of Toronto medical family, unfortunately the majority, whom I will not have an opportunity to approach more directly.

Frederick H. Lowy
Dean

tablet

Winter 1984
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Faculty Ties

To those of us who have studied and worked here, our bonds to the Faculty are a source of pride and pleasure. We feel good about being here — about our ties to a venerable and vital part of Canadian achievement.

Identification with the Faculty has been purely a state of mind until recently. Now, it's a state of dress, too: classic ties designed exclusively for the Faculty of Medicine have just arrived from France and Italy.

THE FIRST FACULTY TIE EVER is available to those faculty associates who wish to make a personal and tasteful statement of affiliation.

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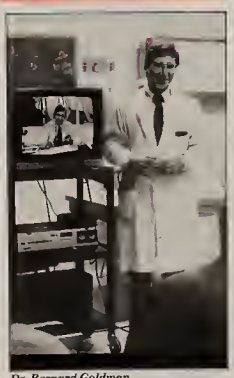
Videos Reassure Patients

Hardly any other medical procedure in recent times has received as much attention or been as widely debated as coronary bypass surgery which is now the most frequently performed major operation in North America.

"With low risks and phenomenally successful results," comments Dr. Ronald J. Baird, Chairman of the Department of Surgery's Division of Cardiology and head of the cardiovascular surgery unit at Toronto General Hospital, "bypass surgery is now considered no more hazardous than many other operations, such as gallbladder removal, for some patients." During 1981, 2,401 patients in Metropolitan Toronto received aorto-coronary bypass operations, with an average survival rate of 98 per cent. Dr. Bernard Goldman, also a cardiovascular surgeon at the Toronto General Hospital, notes that the 1982-3 mortality rate for coronary bypass procedures was only 0.9 per cent or one in a hundred.

The mortality for this type of heart surgery has dropped from about 30 per cent in the 1970's to the present low figure due to a number of scientific advances, especially in cardioplegia — keeping the heart cold and still during surgery — the experimental use of the intra-aortic ballon pump, and improved post-operative care.

Much of the pioneering work in cardiac surgery was done at the University of Toronto and its teaching hospitals. Now some pioneering of a different kind is making coronary bypass surgery even safer with the aid of patient video tapes, also developed at the University of Toronto.



Dr. Bernard Goldman

VIDEOS HELP ALLAY FEARS ABOUT HEART OPERATION

The IMS (Instructional Media Services) department, at the University of Toronto's Medical Faculty, recently produced a series of videotapes designed to inform and educate patients undergoing coronary bypass surgery. The tapes help to reduce fears about the bypass procedure and hospital events prior to, during, and after surgery, alerting patients to natural feelings and emotions they may face. These instructional videos aim to allay anxiety by replacing vague apprehension and imagined events with valid expectotions and a realistic view of the procedure, making recovery as fast, safe and comfortable as possible.

Although bypass surgery has become a common — in some centres almost routine — procedure, with expert teams, advanced equipment, skilled nursing and accurate post-operative monitoring, many patients remain very apprehensive about it. The anxiety that accompanies most surgery is magnified with the heart because of its symbolic significance as "the centre of life." Tampering with the heart seems worse than operating on other organs even though the actual risks may be no greater. By explaining clearly what a coronary bypass is, as well as its benefits, the videos help to diminish concerns regarding post-operative pain and recovery, the effects on the patient's family, job and sex life.

GOOD RESPONSE TO THREE PATIENT EDUCATION VIDEOS

"The response to these videotapes has been superb," reports Dr. Goldman. "We now bring our patients into hospital earlier to allow them and their relatives or friends to see the first tape before surgery." This gives the bypass patient time to absorb the events about to take place, to ask any questions and discuss any concerns.

The videotapes were financed and sponsored by the cardiovascular surgery department of Toronto General Hospital, together with a generous donation from a former bypass patient who discerned the need for better pre and post-operative information. This patient, an active businessman then, says that he found the information he received before surgery, while on the wards and at the time of discharge both "conflicting and ambiguous." According to him, "one person gave instructions that directly contradicted those of another about crucial issues such as diet, exercise and return to work."

To meet the need for information, the cardiac team of Toronto General Hospital, including five cardiovascular surgeons, several cardiologists, nurses, physiotherapists and rehabilitation staff, undertook and collaborated on the video production, supervising the scripting and taking part in production. The IMS production crew spent several days taping in the hospital operating rooms, intensive care units, wards and rehabilitation centre.

Attesting to the success of coronary bypass surgery, the videos show several patients who underwent a bypass operation and were able to resume normal, active, meaningful lives. One lawyer who before surgery was barely able to cross a room without severe angina, now runs five miles a day only eight months after his bypass with appropriate rehabilitation and training. Another patient, a carpenter, forced to quit work because of his heart problems, is back on the job six months post-operatively. A saleswoman of 62 has not only been freed completely of angina three months after her bypass but, weather permitting, cycles to work each day. And finally, a biochemist of 59 who was barely able to climb the stairs before surgery is now back skiing, playing tennis and yachting actively.

PREPARING FOR SURGERY

The first tape prepares the patient for the hospital experience, describing the feelings and events prior to surgery, how best to cope with anxiety, what to expect in the days following surgery, the usual transition from intensive care back to the cardiac ward, and when and how family and friends can visit. The initiation of a self-care and activity regime as soon as possible after surgery is emphasized, taking a positive, upbeat approach throughout. This tape could be viewed in the doctor's office or in the hospital after admission.

Explains one patient, a woman of 68 who saw the tape, "it was a great help, especially in letting me know that all those ghastly tubes in intensive care would only stay in a day or two." Information such as this not only makes patients more tolerant and cooperative while in the ICU but also reassures relatives and other visitors.

GOING HOME AFTER BYPASS

This tape, intended to be viewed prior to discharge, in the company of a relative or friend, prepares the patient for the first six weeks at home after surgery. It aims to speed recovery by giving specific information on follow-up routines, diet, incision care, resumption of sexual activity and return to work. Patients are encouraged to take responsibility for their own health, advised to adopt a steady increase in activity within safe limits, urged to discuss any personal or family problems openly and shown the advantages of joining a cardiac rehabilitation program.

Commented one patient, "it was a relief to know that the chest pains I experienced were not due to heart trouble but to normal healing." Another found the tips on exercise most helpful, while a third patient was encouraged to know that post-op family conflicts were commonplace and that professionals were available to give advice.

ADVANCES IN CARDIAC SURGERY

The final tape shown to recovering patients while in hospital — if they are interested — describes some of the scientific advances and milestones pioneered by scientists, physicians and surgeons at the University of Toronto, especially at Toronto General Hospital, one of the largest centres in North America for heart surgery, and a training ground for many leading cardiac surgeons in Canada. It is designed to elicit interest in research activities and raise funds for their continuation

This videotape includes details of the surgeons who took part in the production including Dr. Bernard Goldman at the pacemaker clinic — a telephone-linked, computerized clinic. One of the largest in North America, it helps monitor patients and keep them well. The other cardiac surgeons featured are: Doctors Ronald Baird, Hugh Scully, Richard Weisel, and Linda Mickleborough.

PREVENTION IS THE ULTIMATE GOAL

The videos emphasize that although surgery can, and often does, remove the symptoms of coronary disease with a better than two thirds chance that angina will be banished, it does not eradicate the atherosclerosis which still progresses. "It's up to patients," states Dr. Goldman, "to adopt a lifestyle that helps them fight their disease — to eat sensibly, avoid being overweight, exercise sufficiently, cut down on stress and above all to quit smoking."

All three videos can be screened or viewed at the Medical Faculty and purchased or rented by hospitals, teaching organizations or individuals. Those interested should contact the Instructional Media Services, University of Toronto, Medical Sciences Building, Toronto, Ontario, M5S 1A8 (or phone Stella Hawke at 416-978-6302).

Exploring Laboratory Teaching

In each issue of TABLET, Dialogue will look at specific issues in medical education and research at the University. Here, Barry Zimmerman, a 1965 graduate of the University and currently Chief, The Division of Allergy, Hospital for Sick Children and Associate Professor of Pediatrics, University of Toronto, and Richard Tiberius, Associate Professor in the Division of Studies in Medical Education and the Department of Family and Community Medicine discuss their concerns and suggestions for laboratory teaching. Dialogue is a frank discussion by individuals — it does not neeessarily reflect the opinions of the University.

Your reaction to the comments expressed is welcome and should be sent to: The Editor, TABLET, Faculty of Medicine, University of Toronto, M5S 1A8.

"Lectures are like creating a Yellow Pages, and no-one goes to the Yellow Pages, unless they first have something they want to buy."

Richard Tiberius

"At this university, laboratories have become too much of a spectator sport..."

Barry Zimmerman

Z The basic point that I would like to make for a start is that at this university, student learning is too much of a spectator sport.

And by taking laboratories and "trivializing" them in order to make them manageable and to fit them into the curriculum, we have essentially "gutted" what labs should be all about. So the immunology labs become five or six different ways of a student recognizing when an antigen comes together with an antibody without an understanding of why the technique was developed. The students are spectators and they don't understand that technology is just a way to solve problems. We need to regain a sense of how the experiments or techniques fit into the total area — in my case into Immunology.

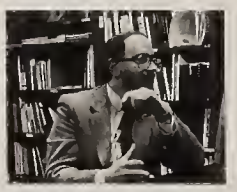
T How do we make it better?

Z We have to start with a clinical problem.

T Why do we need labs at all? We don't need the physical laboratory setting to present a clinical problem.

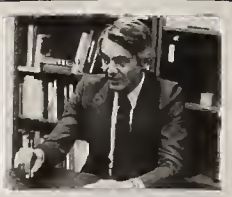
Z We don't need to demonstrate technology. We need to demonstrate how the technology contributes to the sum total of human knowledge. That's where I'd like to see more thrust.

T So in some sense you are saying you want to set up the same kind of problem that the original researchers faced when they devised those techniques. The implication I get from what you're saying is that you're not training clinicians ... you're training researchers who have to invent new techniques. But the great majority of our students are never going to be researchers.



Z Well let me stop you there. The great majority of our students come to the bedside without ever having used their critical faculties. The great majority of our students do not know how — in my opinion — to approach a clinical problem like a problem that's there to be solved. I don't separate my approach in research from that at the bedside. You isolate the problem, you put it in perspective, you analyse the parts, you follow a process that says if such and such occurs, then such and such follows and look at the ramification of that.

T I can understand inculcating the thinking strategy in students that follows the thought process of a researcher. And I buy your argument. But still, why do we have to put people through labs in which techniques are being used and one gets an understanding for those techniques? Surely you can't stop in the middle of a differential diagnosis and say, "This is a tough one, I can't recognize the pattern



... I'd better go back to my lab and invent a whole different technique?"

Z Wait a minute ... that's a misunderstanding. I'm not saying people have to invent techniques; just recognize how technology is just a means to an end. Unless you use it correctly you never get answers. Really what we're talking about is information and a laboratory is a set-up whereby you can control nature — and you can't at the bedside. So you can take a small piece of a problem and isolate the variables. You can control it and actually ask where things are going, applying technology to answer those questions. At the bedside you have far less control over the variables. But the thinking process is often just the same.

Students should be putting together hypotheses as they study ... then in the physical exam, which is laboratory in the sense that it's hands-on, they're using the information they gather against the hypothesis.

Let's face it, there's no back of the book for life ... no answers to flip to. Students have to be comfortable that there aren't going to be written answers. But if things are consistent and you establish a pattern, you can infer what the next step will be. That's what a lab is. So I certainly wouldn't ask a student — or a medical practioner to set up clinical research or develop new techniques. But I would ask that they approach each patient critically, asking certain questions, getting certain answers before going to the literature to see if someone else has set that problem up critically.

The labs that I've seen here have decayed so that students begin to learn trivia about techniques that are already 20 years out of date without a feeling for how the techniques were used to solve problems. Instead they're concerned about things they'll never see or hear again. I agree with you that the vast majority of students aren't going to go into research so why do they need laboratories? They don't need to know laboratory for the sake of laboratory. They need to know how to utilize the information you get both from a lab and from a physical exam — which is just a laboratory at the bedside. The problem is both to gain the data and make use of it.

So that's the experience I would like the students to have. And I'm not saying it isn't difficult.

"There's no back of the book for life"

T So it's the lab as clinical thinking in microcosm and clinical observation in microcosm.

Z Yes but it's become too much of a trivial pursuit as students try to gather all information up in preparation for exams without distinguishing what's important.

T But surely that's just one concept of a lab. There must be other functions a lab can serve? For example, I once saw the defibrillation of a dog experiment in cardiovascular physiology. It seemed to me that what they were seeing was the actual functioning of a whole cluster of physiological phenomena that are inter-related. And unlike the clinical situation which is so uncontrolled — they were able to see exactly what was happening because in fact they caused it to happen. Those students around that dog were watching a cardiovascular phenomenon that was so rich in information because the processes that normally go on covertly were now evident to them. Isn't this the lab as demonstration? It's not words in a textbook, nor is it as hidden as a clinical situation. Is this not a legitimate function?

Z It's a function as a visual aid. Like the visual situation, you use the lab to act as a focal point and help the student to remember large quantities of data. But I would hope that it's not simply passive. What you've described still goes with my first

"It's become too much of a trival pursuit..."

thesis — that this has become medicine as a spectator sport.

T But looking at the lab as a visual aid, I don't know that a person needs to be active. What I'm saying is that seeing is an integrative process. You're looking at the dog directly and at the same time you can see cardiac output and the other monitors and sources of information. For example, I remember when every student in this experiment would have had a dog. Then it became clusters of five or six students to a dog. Now it's one demonstrator and the dog. I can envisage a time when it will be a film of the experiment.

So my question is this: When does it lose its value as a visual aid? I'm suggesting that it's not when the student moves from active to passive but when the richness of the stimulation is reduced.

Z Well I would argue that it is when there is a group of five or six people and we get passivity. Because of that group, four are actually doing something else. Two are involved and the rest have accepted that it's just a model so they can go off and read. So the reason I'm opposed is that I don't believe you can retain the information unless you're committed — unless you actually take part.

T You've used two rather abstract words "trivialize" and "involve." I'm beginning to realize that by involvement you mean a kind of intellectual engagement. In other words you require the student to solve a problem that rivets his/her attention to the situation. And I'm wondering if you're not right. I remember the botany classes I used to attend as an undergraduate and how it was impossible to get students to attend to very visual stimuli unless we were asked to draw them which forced us to observe more carefully. So you're saying that the way to integrate and understand a phenomenon is to force someone to make a decision about it in some way. That's what you mean by involved.

Z There was a time when we forced students to do everything — sit at their microscopes or whatever. I'm not saying we have to go back to that level. But as we moved away from this personal involvement we did lose something and we have to find a way to get that engagement back. Now with our current testing system — with multiple choice exams — students are so geared towards a lab exam that they won't look at the question to see the larger perspective and why they want this information. So time spent now on relatively trivial subject matter towards the multiple choice exam could actually be appropriated towards an experience where the students do run with something in the lab. Now that may call for changing concepts and changes to curriculum.

T Barry, I see you suggesting that we actually turn the sequence back to front ... and use the labs to generate an exciting issue, then use the lectures, textbooks, etc., to fill in the blanks and complete the answers, having first engaged the student in the small group setting.

Z Yes, strangely enough this really isn't a new concept. Things seem to cycle back and forth. It's basically the old idea that you see patient material and try to learn around it.

Thinking about McMaster, where students can go to the bedside very early in their medical training, it forces students to come to grips with the fact they don't know enough to put all this together. They come away charged up and motivated to learn. It's not a laboratory necessarily but it is small groups and it is part of what I believe is missing here.

T I've observed a lot of lectures in the course of improving teaching in this faculty, and by and large what the lecturers are trying to do is to organize a body of material so students can find their way through it. And they need it. And lectures are not a bad tool for doing that. What you're saying is that's like creating a Yellow Pages and no one goes to the Yellow Pages until they first have something they want to buy. You're saying get them hooked on something they want to look up in the Yellow Pages first in the lab, then when they get the organization in the lecture, it will be meaningful to them.

Z In essence I guess I'm suggesting that there are a number of things that engage a student's attention. First there is the symmetry or beauty of the discipline itself — for example in immunology itself. The second thing, though, is where that discipline fits in the whole scheme of medicine. The small group setting can make that material living to them, make it part of problem solving.

T If we go back to basics in education, students don't learn anything unless they're motivated. And motivation largely consists of making connections between the material being presented and the student's interests or orientation. You've mentioned a number of these motivations. Obviously if they're professional

students and they want to be competent physicians, then clinical problem solving is the goal and if you can connect to that, you have a tap into their motivation. Also, there is intellectual problem solving — just being engaged is motivating in and of itself. And you are further saying that laboratories, of the type that generate questions that students find engaging, will facilitate both of those kinds of motivation. The role of the lecture is towards a third kind ... towards aesthetic motivation — what you called the beauty of the subject matter — the intrinsic interest in how molecules combine and form compositions, how the brain works, or how the bones are articulated.

So lectures or textbooks operate to supply that kind of overview, to connect with that motivation which arises out of the beauty of the subject matter, and to supply the organization of the material which students need once they've been stimulated by the clinical or intellectual problem solving of the lab.

Z Exactly. Let me go back to my original premise that laboratories here have become too passive, and I'll tell you a terrible story or joke that I used to relate years ago. It goes like this... each year the Immunology labs would start out with my students saying that they didn't know any Immunology because they'd just finished a Pharmacology exam. But if I would either cancel the first lab or just talk about Immunology, they would come back after the weekend and they'd know something. So the lab would start off with me at the front "talking Immunology." Now the way I'd describe this is that I'd start to "dance a little bit" for these students. Then they would applaud. Then I'd dance a little bit harder because they were applauding. And on it went. Then the next week, when they came in for the second session, I'd say "now it's your turn to dance." But they'd say gee, we don't know how to dance and you danced so well

"We have to find a way to get the engagement back..."

last time, why don't you dance some more. And that's one of the ways that labs become passive ... because you've engaged the student by entertainment value. And I obviously have some real concerns about that because I ask myself, who is going to entertain these students after graduation and the answer of course is the drug companies. Now I'm not saying that entertainment doesn't serve a function but it cannot be the only vehicle. There's no question that I enjoy stimulating people towards coming back and saying they'd like to follow through on a particular subject. But I think what you need is the mix of ways to reach the students, with students taking on some responsibility for their own education. And I think labs can be used in the same fashion.

First Women in Medicine

Augusta Stowe-Gullen, M.D., 1883
The first woman to graduate from Victoria University (now affiliated with the University of Toronto) and the first to receive a medical degree in Canada.
Photograph courtesy of Victoria University Archives

Other Pioneers

There were many other women doctors who made major contributions to medicine in Canada or internationally. These are only a few of Canada's other pioneers.

Maude Abbott One of the Federation of Medical Women of Canada founders, Dr. Abbott graduated too early to have been admitted to McGill University Medical School, but McGill later awarded her an honorary MD CM and appointed her Lecturer in Pathology in 1910.

Lady Banting Wife of Sir Frederick, Lady Henrietta Banting served in the Royal Canadian Army Medical Corps, undertook post graduate training in England and taught at the University Medical School in Hong Kong. Appointed Director of the Women's College Hospital Cancer Detection Clinic, she held this position until her retirement in 1971.

Gladys Boyd One of the first physicians to treat diabetic children with insulin, Dr. Boyd became an internationally recognized authority on childhood nephritis.

Jessie Gray The first woman to earn a Master of Surgery degree and the first woman resident surgeon at Toronto General Hospital, Dr. Gray was considered one of the four leading cancer surgeons in North America.

Marion Hilliard A University of Toronto Faculty of Medicine graduate, Dr. Hilliard later became Chief of Obstetrics and Gynaecology at Women's College Hospital. It was during her term as Chief that the hospital was accorded teaching status by the university.

Maude Menten Another early graduate from the University of Toronto Faculty of Medicine (class of 1907), Dr. Menten earned an international reputation for her discoveries relating to blood sugar, hemoglobin and kidney functions.

Ontario Medical College for Women (1906) Photo courtesy University of Toronto Archives

When bacteriologist and medical practitioner Dr. Eva Macdonald succeeded Pauline McGibbon as Chancellor of the University of Toronto in 1974, it marked a 100th anniversary of sorts. Just over one hundred years before, Emily Stowe and Jennie Trout had managed to "slip" into the all-male Toronto School of Medicine, beginning what was to be a troubled and often confusing history of the medical education and practice of women in Canada.

Yet, by the 1970's, more than 25 per cent of the medical students attending Canadian universities were women, and the election of Dr. Macdonald as Chancellor could be taken as a sign of the final recognition of the exceptional work of Canada's "lady doctors."

AN UNUSUAL BEGINNING

It is not surprising that Victorian and conservative Canada trailed her southern neighbour in the acceptance of women in medicine. The United States could boast of the first woman doctor in the world, Elizabeth Blackwell, who in 1849 graduated from Geneva Medical College in New York State. And when the Geneva College tried to reverse its decision by refusing to admit any additional women after Dr. Blackwell's graduation, she found a new answer by raising support for a woman's medical college — the first of three which soon sprang up in the eastern states.

In Canada, the history of medical women arguably begins with Dr. James Miranda Barry, an English army physician whose 43 years of practice included a final appointment as Inspector General of Hospitals for the united province of Upper and Lower Canada. The word "arguable" applies not to Dr. Barry's experience or reputation, but to her sex. Born James Barry and raised as a man, it was not until Dr. Barry's death in 1865 that a maid preparing the body for burial discovered the surgeon had breasts and female genitalia.

Barely five feet tall and with a delicate physique, the doctor had hidden her sexual identity through four decades of army living. Pleading shyness, extreme even by Victorian standards, Barry refused physical examinations and avoided shared accomodation throughout her life. Although in her 60's by the time she arrived in Montreal, the doctor continued to exhibit the outspoken nature that marked her career. She lobbied for comfortable living quarters for the enlisted men and their wives, more nutritious and interesting meals for the troops, improved sewage and drainage facilities in the barracks and the provision of social and intellectual activities to enrich the army life.

Interestingly, Dr. Barry's death certificate stated that her sex was male and to this day historians speculate about the true identity of this remarkable person. Was she/he a woman or a hermaphrodite? Although never confirmed, most anecdotal and documented evidence points to the fact that Dr. Barry was indeed a woman who, for an entire lifetime, managed to do what had always been considered a man's job.

THE CANADIANS

Although Dr. Barry's experience represents a tremendous career of medical reform for any man or woman, it was Emily Stowe, Jennie Trout and the women who followed them who paved the way for an ongoing program of medical education for women in Canada. Although both Stowe and Trout were forced to pursue their degrees in the U.S., their battles and subsequent licensing opened the doors for the establishment of Canadian institutions for women.

Emily Jennings Stowe is in many ways our most famous "pioneer lady doctor." Born to Quaker parents and an ardent suffragette herself, she became a school teacher and, soon after, Canada's first woman school principal in 1854.

Two years later, Emily Jennings married John Stowe, leaving her work for the new role of homemaker.

Several years and three children later, Emily again returned to teaching, this time to support her ailing husband — hospitalized with tuberculosis — and her family. Faced with a low-paying teaching position, John's illness and a great belief in the need for women doctors, Emily made the unprecedented decision to become a doctor.

Stowe's quest began with application to Toronto's Victoria College medical course in 1863. Refused admission because of the school's all-male policy, she applied and was accepted at New York's Medical College of Women in New York City. In 1867 she emerged victorious, medical degree in hand, and promptly set up practice in Toronto.

Because foreign degrees were not recognized in Canada, Stowe was actually practising illegally since the College of Physicians and Surgeons refused to grant her a licence. Study in Canada would qualify her, but since no university would accept women students, Stowe was completely blocked.

In 1870 however, due more to Emily Stowe's persistent applications than a softening in attitudes, Stowe and Mrs. Jennie Gowanlock Trout, ten years her junior, were allowed to attend a series of lectures at the Toronto School of Medicine. Their joy was short-lived.

Subject to a variety of personal humiliations, the two women found embarassing cadaver parts left on their seats, crude drawings sketched on the walls (causing one classroom to be whitewashed four times in a single year) and rude anecdotes by the male instructors. The ladies found a partial solution to the bawdy stories by threatening one particularly troublesome lecturer that they would tell his wife. His classes, they reported, were "more bearable" after that.

Despite their joint resolve, the atmosphere took its toll and within the first year, Jennie Trout left Toronto to enroll in the Women's Medical College of Pennsylvania. After graduating in 1875, she returned to Toronto where she took her matriculation exam with the Council of the College of Physicians and Surgeons, becoming the first woman licensed to practice medicine in Canada.

Stowe remained at the Toronto Medical School but because of her fear of failure and general resentment of the all-male examining council, refused to take the oral and written exams until 1880.

Dr. Augusta Stowe-Gullen (1857-1943)
Photo courtesy of Victoria University Archives

Dr. Jennie Trout (1841-1921)
Photo courtesy Queen's University Archives

Old University of Toronto Medical Building (1904-1968)
Photo courtesy University of Toronto Archives

THE NEXT PHASE

The years following the establishment of Drs. Stowe and Trout in Toronto saw considerable advances in medical education and treatment for women in Canada.

One of the most significant was the graduation of the first woman to pursue and complete medical studies at a Canadian University. She was none other than Augusta Stowe, daughter of Emily, and she graduated from Victoria College in 1883.

1883 was a significant year for another reason as well — driven in large part by the efforts of Jennie Trout — medical colleges for women were established in Toronto and Kingston.

Although the history books do not make it clear, it seems that sometime after Jennie Trout set up a licensed practice in a Jarvis Street Clinic there occurred a split in the friendship she enjoyed with Dr. Stowe.

Trout, a sweet-natured quiet woman may have found the strident feminist policies of the more forward "scientific socialist" (as Stowe referred to herself) a little more than she could manage. Whatever the reason, when Trout decided to found a college for the medical education of women, Emily Stowe was not at her side.

Instead, Jennie Trout had to try it alone. She insisted that her personal $10,000 contribution towards the college would only be forthcoming on the condition that women were allowed to sit on the institution's governing board and to act as staff members. The academic community — including Dr. Michael Barrett, professor of physiology and a sympathetic friend of Stowe's — balked.

At Queen's University in Kingston, however, Trout received a more affable reception for her idea from Dr. A. F. Knight, one of the matriculant examiners. Curriculum organizers at Queen's, having already set up a summer medical course for women in 1880, were not as adverse to the idea as their Toronto colleagues. Accordingly, with the personal and financial assistance of Dr. Trout, arrangements were made to set up a women's medical college in the fall of 1883.

Faced with the certainty of a Kingston medical college for women, academics in Toronto had a sudden change of heart. Apparently feeling the pressure to set the pace for medical education in the province, they decided to go ahead with their own plans for a women's college within three days of the Kingston announcement.

Both colleges opened in October 1883. The Kingston facility had three students enrolled while Toronto had one student who had transferred from the special summer course at Queen's.

The Toronto Women's Medical College (affiliated with the University of Trinity College and the University of Toronto) was housed in a three-storey brownstone. In 1898, the basement of the college opened as the first clinic in the city devoted to women. Staffed by two women doctors — Jennie Gray and Ida Lynd, the clinic developed into the Women's College Hospital and Dispensary Board, moving to its own premises in 1910.

Ten years after the opening of the two women's colleges — and with 135 graduates between them — the two colleges merged to become the Toronto-based Ontario Medical College for Women.

THE TWENTIETH CENTURY

If the years before 1900 were marked by a handful of women whose "indomitable" will enabled them not only to defy but actually reshape the system, then the post 1900 years reflected a growing community of women physicians.

For the first time, women were active in the administrative and academic world of the hospitals and universities. Augusta Stowe-Gullen (who married a fellow class mate one week after graduation) became the first female staff member at the Women's Medical College and, by 1906, one third of the staff was comprised of women. In time, Stowe-Gullen became a Professor of Diseases of Children as well as President of the Alumni Association and a college director. Dedicated to numerous causes — including the Canadian Suffrage Association — she was awarded the King's Medal in 1935 and died aged 86 in 1943.

Although the Women's Medical College was amalgamated with the University of Toronto in 1906, Women's College Hospital continued to provide a focal point for the growing numbers of medical women in the city.

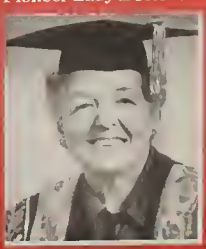
By 1924, women doctors gained an additional sense of community with the creation of the Federation of Medical Women of Canada. The Federation founders became a "who's who" of medical women themselves. There was Dr. Helen MacMurchy, the first president, who was appointed chief of the Division of Child Welfare in the Federal Department of Health from 1920 to 1934. She authored numerous reports and booklets including "The Canadian Mother's Book", a general reference book to help women understand childhood diseases; by 1940 it had sold over 1 million copies. Voted one of the 10 most remarkable women doctors in the western world in 1949, she was invited to attend a celebration on the 100th anniversary of Dr. Elizabeth Blackwell's graduation as the first woman doctor.

The founding members of the Federation also included Dr. Jennie Smillie Robertson, one of the earliest graduates from the Faculty of Medicine after the Ontario Women's Medical College had merged with it. One of the first women to practise surgery in Canada, she was the first to perform major surgery at Women's College Hospital.

Joining them was Dr. Elizabeth Bagshaw, a Hamilton-based general practitioner who pioneered the dispensing of birth control devices and information to the needy, despite considerable opposition by church officials and despite federal legislation in effect at the time. Dr. Bagshaw is evidence of the longevity of many of the strong willed "pioneers." Made a Member of the Order of Canada in 1973, she flew to Ottawa to accept the award — at the age of 92. She was later honoured with a documentary by the National Film Board and died some months after her 100th birthday.

These women, and the hundreds of others who were studying and practising at the time, transformed the perceptions of their male teachers and colleagues through their tenacity, their intelligence, and their compassion. The ultimate testament they left is not just the advancement of women in medicine. It is the advancement of medicine itself — through research, through clinical techniques, and above all through a belief that things can be changed for the better.

Former U of T Chancellor One Of Canada's Pioneer Lady Doctors



Dr. Eva Macdonald as Chancellor
Photo courtesy University of Toronto, Information Services

Ask Dr. Eva Macdonald if she was surprised to be elected the 25th Chancellor of the University of Toronto, and she will respond that she was "never so surprised about anything in (her) entire life." The former Dalhousie graduate figured that her alma mater alone would eliminate her from consideration. It didn't, and in 1974 she took on a three year assignment that showed her "how much support the students need and how much everyone gives to the University."

Now 82 and living alone in Toronto since her husband's death in 1980, Dr. Macdonald remains the kind of person about whom the descriptions "still..." ("still dynamic", "still active") seem only to diminish the vitality and grace that have characterized her throughout her medical career.

continued from page 7
"Former U of T Chancellor"

Born the daughter of a Halifax physician in 1902, medicine was never a radical choice for Dr. Macdonald. Both her brothers became doctors and her father added a private hospital to his existing practice shortly before the First World War. Remembers Dr. Macdonald, "there were always medical chores that needed doing."

Although she originally planned to become a nurse, she discovered it would take seven years of study to complete a University liberal arts program and a nursing diploma — the same length of time required for a medical degree. In 1920, she enrolled at Dalhousie University's School of Medicine, one of two women in a 50-student class.

Following her graduation in 1927 and internship in Halifax, Dr. Macdonald journeyed to Toronto in 1929 to pursue her Diploma in Public Health on a fellowship at the University of Toronto's School of Hygiene. Five months into her program, she contracted scarlet fever, and spent 4 months in an isolation ward. By the time she recovered and finished her work, she had made the decision to stay in Ontario.

From 1929 to 1933, Dr. Macdonald was on staff as a teacher and researcher with the University of Toronto's School of Hygiene as well as acting as physician to the nurses at Women's College Hospital.

Then in the Depression year of 1933 all married women staff members of the Faculty of Medicine were asked to resign in order to preserve the job security of male physicians with families to support. Forced to leave the university, Dr.Macdonald became physician to the Children's Aid Society and gained additional clinical experience by holding many medical clinics through the Out-Patient Department of Women's College Hospital.

In the 1940's Dr. Macdonald returned to research and the University of Toronto, working on immunization for tuberculosis and diptheria as well as the development of blood banks for transfusions and penicillin research.

"Those were exciting times in medicine," says Dr. Macdonald, "we saw the killer diseases of the '30's being wiped out in the '40's. Imagine that when I was growing up, it took five to ten years before a patient recovered from tuberculosis — and most of them didn't recover completely. Now in a few months, you're back at work again."

Her laboratory work gave way to private practice in the 1950's — a practice which continued until 1961 when her husband retired. Dr. Macdonald says it was difficult to give up the years she describes as "the most enjoyable time of my career."

Perhaps because of this, Dr. Macdonald continued to devote one day a week to the hospital's cancer detection clinic until the second year of her term as Chancellor. "In some ways," she laughs, "I think I took the Chancellorship to get out of medicine. I found it very difficult not to practice — I loved my patients and my work." As Chancellor, she transfered that energy into public speaking, talking with students, carrying out the formal parts of the position "and enjoying it."

Dr. Macdonald is still active in the support of medical women. A driving force behind the research, writing and publication of Carlotta Hacker's *The Indomitable Lady Doctors* published in 1974, she regrets that the book could cover only the period until 1924. "There are so many exceptional women missing from it. People like Edith Gordon, Gwen Mulock, Holly McKinnon and their successors who manned the Health Centre for Women on campus. People like Marion Kerr, one of the first Canadian woman gynaecologists, or Jessie Gray, the first woman Fellow of the Royal College of Surgeons of Canada."

And most of all, Dr. Macdonald regrets the omission of Dr. Marion Hilliard, her flatmate in the early years following the two women doctors' graduation in 1927. "She was the most dynamic individual I think I have ever known" says Dr. Macdonald of the woman who later became a successful author and Chief of the Obstetrics and Gynaecology department at Women's College Hospital. The two met through Dr. Macdonald's sister (who announced to a young Marion Hilliard that she had "a sister exactly like you") and continued their friendship until Dr. Hilliard's death in 1958.

Why is Dr. Macdonald so devoted to the cause of publicizing these pioneers? "They were all exceptional women and doctors. I don't think any woman could study medicine then unless she was exceptional — the road was a little rockier."

Editor's Note:
Dr. Eva MacDonald celebrated her 82nd birthday on October 7. She continues to pursue an active schedule in the support of Canada's medical women.

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TABLET should reflect the interests and concerns of its readership: the faculty, alumni, staff and students of the University of Toronto Faculty of Medicine.

Help make this happen by submitting your ideas, comments or letters-to-the-editor for future issues. TABLET will also feature occasional essays by alumni on topics we feel will be of interest to our readers.

Write: The Editor
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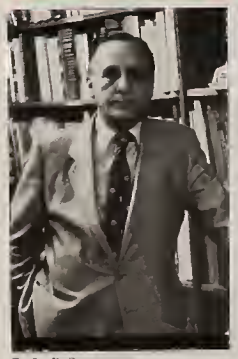
In each issue of TABLET we will include a feature on one department within the Faculty of Medicine. In this, our debut issue of TABLET, we acknowledge the people and projects of a department that was created in February of 1983 by the merger of the Department of Medical Microbiology and the Department of Microbiology and Parasitology. We think even Faculty of Medicine staff and alumni will be surprised and impressed by the scope of the work now being undertaken by this group of physicians and microbiologists.

The Department of Microbiology



Dr. Leslie Spence

Extensive Interests and Expertise Characterise Microbiology Department

An old discipline and a new department. That's how Chairman Dr. Leslie Spence describes Microbiology at the University of Toronto. Although the University has been teaching bacteriology since 1897, it was only last year that the merger of the Departments of Medical Microbiology and Microbiology and Parasitology created the present department now housed in the Fitzgerald Building, the Banting Institute and various teaching hospitals.

Composed of scientists in Microbiology as well as medical doctors, the department is involved in many areas of teaching, patient services and research with 25 of the 45 staff members holding additional appointments elsewhere — a fact which attests to the diversity of the people and projects associated with the department.

Real World Problems

According to Dr. Spence, they see their role as dealing with "real world problems" rather than pursuing research in an isolated ivory tower. To support this claim, they are quick to identify a department mandate that supports community and patient service, improved teaching standards and the general advancement of our understanding of microbes.

The department's teaching extends to nearly 2,000 students annually including arts and science undergraduates, community health, nursing, pharmacy and dentistry students as well as those in the undergraduate medical course and graduate programs in microbiology.

In addition to consultation with individual physicians, faculty members will speak at non-teaching hospitals and they remain open to inquiries from practicing physicians looking for assistance on microbiological issues. There are also weekly infectious disease teaching rounds offered at Mount Sinai and Toronto General Hospital, open to any interested doctors. As Dr. Spence puts it, they have, "an applied interest in disease." Says Spence, "We are interested in the problems that microbes cause, not only the microbes themselves."

Microbiology Increasing in Importance

Dr. Spence believes that microbiology is becoming an area of increasing importance to medicine for a number of reasons. First, new advances in transplant surgery are making such procedures more common, and making it clear that we need to solve the problems associated with the risk of infection for immunosuppressed patients."

"Micro-organisms that normally do not produce illness in a healthy person, will produce disease in a patient who has a heart, lung or renal transplant. Microbiology then must develop hand-in-hand with these advances if we are to be successful," he explains.

Secondly, bacteria are continuing to develop new resistances to antibiotics. "Our job is ta make sure that the physician prescribes the right drugs and in fact some members of the department are undertaking molecular studies of antibiotic resistance in bacteria.

"Molecular probes are being used to study the sources of infectious disease outbreaks, how bacteria spread from one host to another and to develop improved diagnostic techniques. These techniques will give a window on the genetic world. Using DNA probes as diagnostic tools, it will be possible ta specifically and selectively identify the cause of diseases," adds Spence.

Community Support

The Department's interest in the community is also reflected in its program of environmentally oriented projects. Research projects cover everything from acid rain in Northern Ontario Lakes to the effects on health of bacterial pollution at Toronto beaches to the national problem of encephalitis-causing viruses transmitted by mosquitoes. The Department has a unique role as the National Arbovirus Reference Service for Canada, monitoring these viruses and coordinating research on them across the country.

There is a great concern with the prevention of epidemics in the community. Department members are involved in rabies studies with a view to control of this disease in wildlife, counselling the Ontario government and working on specific projects such as the field immunization of foxes against the disease. Other targeted areas of study include sexually transmitted and diarrheal diseases.

One special subset of the community concern is the work being done to understand and prevent nosocomial or hospital-acquired diseases. There is a tremendous monetory cost to these infections as a result of prolonged hospital stays as well as the risk of death to a patient who acquires an infection while hospitalized. By understanding how infections spread, the department is hopeful that it will be able to play a role in reducing the incidence of nosocomial infections.

Extensive Research

In addition to community and patient-oriented work, staff members contribute extensively in the area of basic research projects, designed to seek new knowledge of micro-organisms, towards an understanding of how bacteria function and their role in disease.

"We cannot isolate ourselves from what is happening in the world, whether you are talking about leprosy, diarrhea or respiratory disease, there are millions of people affected by the problems microbes can cause," says Dr. Spence. "It's very easy for young doctors in Canada to assume microbial diseases have disappeared. But we have to bear in mind that it's a global village — we get Canadians going abroad and immigrants coming into Canada. A doctor has to understand not only the diseases that occur in Canada but also the diseases that occur elsewhere. This is no sterile discipline we're studying in the abstract. We're talking about real problems in the real world."

Future Plans

To ensure that they continue to keep pace with the field of microbiology, department members look forward to a "regeneration" of staff in coming years. New assistant professors will be added and facilities will be improved to move the Department towards the forefront of the "revolution in biotechnology."

With its conscious focus on building and maintaining communication lines with government, industry and public health groups, the department is convinced that it will continue to play a major role in the future of the field. "We are able to draw on many resources and to tie together the work and interests of industry, basic science, the hospitals and public health" says Dr. Wayne Bradbury, a molecular biologist in the department. As a department, these 46 specialists are committed to dealing with "real world problems" and, thanks to their efforts, we are all a lot closer to some very real solutions.

Readers interested in obtaining a copy of the Department's 1984 Research and Publications index or wishing to discuss a specific aspect of the Department's work, should write:

Dr. Leslie Spence
Chairman
Department of Microbiology
Faculty of Medicine
University of Toronto
Toronto, Ontario M5S 1A8

Appointments

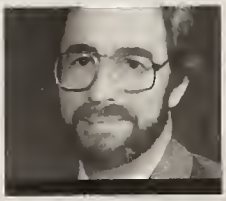
Dr. G. Harvey Anderson has assumed the important position of **Associate Dean — Research** as of October 1, 1984. Dr. Anderson, a widely respected researcher and teacher, will be responsible for advancing research activities across all Faculty departments, and will take charge of research planning at the interface between the faculty and its teaching hospitals. He will continue as Chairman of the Department of Nutrition Sciences until the end of his first term in June 1986, after which this arrangement will be reviewed.

The Faculty has embarked on an energetic program of developing and coordinating neuroscience research and teaching in the Health Science Complex. **Dr. William G. Tatton** has been appointed **Associate Dean — Neurosciences Development** for a three year period (to June 30, 1987). In this position he will develop a Faculty-wide mechanism for coordinated and enhanced activities in neuroscience teaching and patient care and several specific areas of research. This reflects the Faculty's commitment to the development of world class activities in the neurosciences.

A precedent for such an appointment was established many years ago when the Faculty appointed an Associate Dean — Sunnybrook Development for a three year period, to facilitate the integration of the Veterans' Affairs facility at Sunnybrook into the Health Science Complex.

In addition to joining the Decanal team, Dr. Tatton will continue as Director of the Playfair Neuroscience Unit at the Toronto Western Hospital.

Dr. Ed Sellers (Jr.) has been appointed **Associate Dean — Academic Affairs**, succeeding Dr. W. Francombe. Dr. Sellers, formerly Assistant Dean for Undergraduate Curriculum, will continue his involvement with the Addiction Research Foundation, where he served as Clinical Director prior to becoming Associate Dean.



Dr. Arline McLean, a neurologist at Sunnybrook Medical Centre, is the new **Assistant Dean — Undergraduate Affairs**. This position replaces the former student affairs portfolio.

Dr. D. Gordon Potts will become **Chairman of Radiology** effective January 1, 1985, succeeding Dr. E.L. Lansdown. Dr. Potts is an internationally recognized neuroradiologist, who comes to Toronto from Cornell University New York Hospital. He is an expert in the newer imaging techniques.

One of Dr. Potts' major initial challenges will be the advancement of magnetic resonance imaging technology in Toronto. As well as becoming departmental chairman, Dr. Potts will be the Chief of Radiology at the Toronto Western Hospital. He brings creative leadership to the Department, and will help to move the Faculty to the forefront in the development of new imaging techniques.

Sherril Gelmon has been appointed **Faculty Development Coordinator**. She is a graduate of our Master of Health Science in Health Administration program. Ms. Gelmon is responsible for planning and organizational development through the Dean's Office, and will coordinate all Faculty international efforts. She holds a cross-appointment to the Department of Health Administration, and will be teaching in its graduate program.

Alumni Association Presidents for 1984-1985 for the six alumni associations affiliated with the Faculty are:

- Dr. R. Kurdyak, Medical Alumni Association
- Ms. S. Tamblyn, Community Health Alumni Association
- Mrs. J. Perrin, Society of Graduates in Health Administration
- Ms. P. Mador, Physical and Occupational Therapy Alumni Association
- Ms. R. Martin-Adams, Speech Pathology Alumni Association
- Miss E. Begley, Household Science Alumni Association

Medical Society presidents for 1984-1985 are:

- Glyn Morgan, Medical Society
- Kathy Giles and Hilary Jaeger, Medical Women's Association
- Peter White, 4th Year
- Mark Miller, 3rd Year
- Nick Cuberovic, 2nd Year
- Mark Kravis, 1st Year

New Developments

The Faculty's academic organization in Oncology is being reviewed by an interdepartmental, interhospital task force established by the Dean in July. This task force is chaired by **Dr. Burnett Thall**, who is a member of the Board of Trustees of the Ontario Cancer Institute and of Women's College Hospital, as well as a member of the University Governing Council.

The 19-member task force will advise the Dean on the appropriate mechanism for cross-departmental and inter-institutional coordination of teaching, research and service in Oncology. As well, recommendations will be made on the need to establish either a new Department of Radiation Oncology or a Department of Oncology. It is expected that the task force will report to the Dean in January.

In July, a task force on **Magnetic Resonance Imaging (MRI)** was established by the Dean, to develop a Faculty position on MRI, and to respond to the Metropolitan Toronto District Health Council report on diagnostic imaging. Chaired by **Dr. J.T. Marotta**, Associate Dean — Clinical and Institutional Affairs, and including hospital administrators and senior Faculty members, the task force was charged with recommending a unified approach and single University position from the Health Science Complex. The report of the task force is to be presented to the Ministry of Health in the near future and will recommend the acquisition of two new MRI units (in addition to the unit at Princess Margaret Hospital) to be placed in the Health Science Complex. One of the units will be dedicated primarily to clinical service and the second will be used for clinical research as well as service. It is hoped that a third unit for animal and tissue research can be secured through private funding.

Another Faculty of Medicine committee, chaired by **Dr. A. Bruce**, chairman of the Division of Urology, met over the summer to review the potential acquisition of extra corporeal shockwave lithotripsy — a noninvasive method for breaking up ureteral calculi, with possible further application to the treatment of renal and gall bladder stones. The committee, composed of both hospital administrators and clinicians, agreed that this technique has now been demonstrated to be efficacious and is ready to be implemented for systematic clinical and research use.

On the strength of a positive report from the committee, Dean Lowy has written to the Ministry of Health recommending the immediate purchase of the first Ontario unit for our Health Science Complex.

The Ministry presently is reviewing the use of lithotripsy, and has set up a committee, under Dr. Bruce's chairmanship, to advise regarding the siting of the unit.

Reviews — 1984-85 In accordance with current Faculty policy, an external review of a department is conducted at the conclusion of a Chairman's five year term, regardless of whether the chairman is retiring or hopes to serve another term. All departmental staff are invited to participate in the review; other faculty members may participate where they have particular concerns.

Reviews to be held in this academic year include **Anatomy, Art as Applied to Medicine, the Banting and Best Department of Medical Research, the Hannah Chair in the History of Medicine, Preventive Medicine and Biostatistics and Psychiatry.** As well, internal reviews of the **Canadian Liver Foundation Epidemiology Unit, the Bone and Mineral Metabolism Unit,** and an organizational review of the **Teaching Laboratories** will be undertaken.

tablet talk

The Faculty has added its twenty-seventh department with the establishment, on July 1st of the Department of Immunology, with Dr. R.G. Miller as the first chairman. For many years, immunologists have been involved in the teaching, research and clinical programs of several departments, and have conducted graduate teaching through the Institute of Immunology of the School of Graduate Studies. In response to concerns that the strong potential of faculty in this field was not being maximized, a task force reviewed the situation and recommended the establishment of a department.

Dr. Miller currently is developing long-range plans for the department and is organizing a symposium for the spring of 1985 to mark its inauguration. This marks the first time in fifteen years that a new department has been established in the Faculty.

Dr. R.G. Miller

News from the Hospitals

In keeping with a trend to corporate organization of hospitals, four of our fully affiliated teaching hospitals have revamped their organizational structure, converting the position of Executive Director to President. Mr. G. Turner has become President of Mount Sinai Hospital, Mr. J.D. Snedden has become President of the Hospital for Sick Children and Miss A.J. Bailey has become President of the Wellesley Hospital. Toronto Western Hospital has also gone to to a corporate structure with the appointment of a new chief executive officer and President, Mr. C. Hunt. This brings to six the number of presidents (including Mr. W.V. Stoughton of Toronto General Hospital and Dr. M. Barkin of Sunnybrook Medical Centre) in the Health Science Complex.

Dr. Robert Ginsberg has become Surgeon-in-Chief at Mount Sinai Hospital. Dr. Robert Stone is the new Surgeon-in-Chief at the Toronto Western Hospital.

Dr. Ken Shumak has been appointed Physician-in-Chief at Women's College Hospital. He succeeds Dr. Peggy Hill who is retiring, and in whose name Women's College Hospital has established a campaign to raise funds for an endowed chair in medicine.

New Psychiatrists-in-Chief have been appointed at three of the teaching hospitals. Dr. A. Awad has taken up this position at the Wellesley Hospital (moving from Toronto Western Hospital). Dr. Howard Book has been appointed at Women's College Hospital (moving from Mount Sinai Hospital). Dr. Isaac Sakinofsky, who comes to Toronto from McMaster University, has been appointed at St. Michael's Hospital.

A new Pathologist-in-Chief, Dr. Shan Nan Huang, has been appointed at Sunnybrook Medical Center. He was formerly Professor and Chairman of Pathology at Memorial University in Newfoundland.

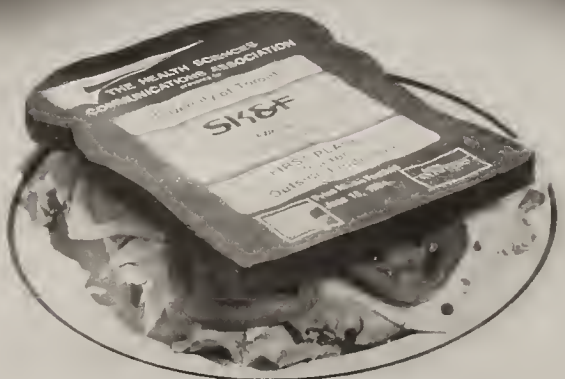
The new Chief of Obstetrics and Gynaecology at the Wellesley Hospital is Dr. Denny DePetrillo. Formerly at McMaster, Dr. DePetrillo will head the division of Gynaecologic Oncology for the Department of Obstetrics and Gynaecology.

New division chiefs have been appointed in many of the hospitals, including Dr. Arnie Frieberg (Plastic Surgery — Toronto Western Hospital), Dr. David Hastings (Orthopaedic Surgery — Wellesley Hospital), Dr. Michael Jewett (Urology — Wellesley Hospital), Dr. Mel Silverman (Nephrology — Toronto General Hospital), and Dr. Paul W. Armstrong (Cardiology — St. Michael's Hospital).

Bits

Dr. R. L. Noble, a 1934 graduate of the University of Toronto is one of three Canadians among the eight 1984 Gairdner Foundation International Awards. He won the award for his work in cancer chemotherapy during the 1950's when he discovered the ▷

THE PICTURE OF HEALTH



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anticancer properties of the Jamaican periwinkle, developed as the drug Vinblastine. Dr. Noble has described his research as "serendipitous" since he made his discovery while doing research on the periwinkle for diabetes treatment. He noticed a peculiar side-effect, pursued it and ultimately discovered the drug's application in cancer treatment. At one time the best drug for Hodgkin's disease, Vinblastine remains a useful drug commonly used in combination with other drug therapies in the treatment of Hodgkins. Dr. Nohle is now associated with the University of British Columbia, Vancouver.

In June of this year, **Dr. Keith L. Moore**, Chairman of the Anatomy Department and Associate Dean, Basic Sciences, of the Faculty of Medicine, received the prestigious **J.C.B. Grant Award from the Canadian Association of Anatomists.** The Award was given to Dr. Moore by the Association, "in recognition of his meritous service and outstanding scholarly accomplishments in the field of anatomical sciences."

Dr Moore says he is delighted with the award because it represents recognition from his colleagues and peers. Dr. Moore is internationally-known for his research in sex chromosome abnormalities and embryology. He has been a member of the Faculty of Medicine at the University of Toronto since 1976. Previous to coming to Toronto, he was Professor of Anatomy and Head of the Department of Anatomy in the Faculties of Medicine and Dentistry at the University of Manitoba. Dr. Moore has published six teaching textbooks, as well as a great number of research articles, on his areas of expertise. Most of his books have been translated into up to seven languages and are used in medical schools and teaching hospitals around the world.

Dr. Moore has received other important awards for his research, writing and lecturing such as: The American Medical Writer's Award for his book "The Developing Human. Clinically Oriented Embryology," in 1974, and the Raymond C. Truex Distinguished Lecturer Award in 1983. He is also one of only four Canadians to have been awarded a Fellowship in the International Academy of Cytology. His most recent, the Grant Award, is the highest honour given to a Canadian Anatomist by the Canadian Association of Anatomists.

The Faculty of Medicine and four teaching hospitals recently received a **$1,000,000 award from the McLaughlin Foundation** to assist in the endowment of hospital-based academic positions in the basic sciences. Our proposal was developed jointly by members of the Faculty and the research institutes at the Hospital for Sick Children, Mount Sinai Hospital, Toronto General Hospital and Toronto Western Hospital. Scientists will be located at these institutions, which have agreed to provide matching funds. It is anticipated that appointments will be made in four areas — molecular biology and genetics, immunology, neurology and neurobiology, and developmental biology.

Professor Nancy Joy, Chairman of the Department of Art as Applied to Medicine, was named a **Fellow of the Ontario College of Art** in June.

Four new fellows were named this year, bringing the number who share this honor to 34.

Professor John Browne has assumed the position of **Principal of Innis College**. Formerly the Faculty Development Officer in Medicine, he will continue to teach in the Graduate Department of Community Health. He also will continue to be responsible for Faculty exchanges with China and with South America.

Professor John Browne

Dr. Douglas Wilson, formerly a Professor in Medicine and head of the division of nephrology at Toronto General Hospital, has moved to Edmonton to become Dean of Medicine at the University of Alberta.

Dr. Eddie Kingstone, who had been Vice-Provost, Health Sciences, has become Chairman of Psychiatry at McMaster University.

Dr. Brian Underdown has moved to McMaster to be the Associate Dean — Research.

The Department of Biochemistry continues to field highly qualified academic staff (primarily its former chairmen) for administrative positions. **Dr. Ron Williams** has become Principal of Scarborough Campus, retaining his position of Professor in Biochemistry. **Dr. George Connell** has, of course, returned to the University of Toronto as President, and has rejoined the Department.

Three Faculty members have been named National Health Research Fellows. They are **Dr. Marie Percy** (Obstetrics and Gynaecology — Mount Sinai Hospital), **Dr. Nancy Cohen** (Psychiatry and Psychology — Thistletown Regional Center) and **Dr. Randy Contes** (Preventive Medicine and Biostatistics).

Paul Marks, a third year medical student, has been awarded the Peter Wright Scholarship from the Canadian Scholarship Trust. This is the first time the award has been made to a Canadian student in professional faculty, and recognizes the student's contribution to the community and the Faculty.

The **Graduate Program in Health Administration** underwent a site visit from the accrediting commission of the Association of University Programs in Health Administration in the spring, and has received full accreditation for a five year period.

Women In Medicine Support Group. Medicine has come a long way in offering educational opportunities to women in Canada from the days of Emily Stowe and Jennie Trout. Women now make up almost 40 percent of the University of Toronto Medical School's new students. Yet there is still strong evidence that during their medical training women are exposed to different kinds of stress than their male colleagues.

Role models among staff at Canadian universities and hospitals are few. Women students continue to be faced with outdated and often derogatory images of the woman patient in gynecological and pharmaceutical literature. There is no "old girl" network and limited access for women to the still existent "old boy" network. And, like all women in the work force, female physicians must make major lifestyle choices regarding career versus child rearing. It was in response to concerns like these that the **Support Group for Women in Medicine** was founded in the spring of 1984. Offering women an opportunity to meet informally on a monthly basis to discuss their experiences and concerns, the group's mandate is to provide support for women dealing with the academic stresses and isolation associated with medical training. The group also offers a chance for "networking" with other women in medical training as well as those who are further on in their careers.

In this one hundredth anniversary year of women at the University of Toronto, the Faculty of Medicine has provided funding to the Women in Medicine Support Group in collaboration with the Medical Women's Association for a symposium on women and stress in medical training. **Murmurs of the Heart: Issues for Women in Medical Training** has been scheduled for Friday, February 8 and Saturday, February 9, 1985. The symposium will open with a keynote speaker and a wine and cheese gathering on Friday, February 8th, followed by workshop sessions on Saturday. The wide range of workshop topics includes Coping with Parenthood, Images of Women as Presented in Medical Education, Balancing Medical Career with Personal Life, Substance Abuse and Occupational Hazards, Part-time Residencies, and Women Physicians Interacting with Other Heath-Care Workers. It is hoped the workshops will provide suggestions for policy development in the Faculty of Medicine. Individuals interested in participating in the organization of the workshops are encouraged to contact Chantal Perrot (537-4773) or Pamela Stewart (leave message at 978-2895) for further information.

tableau

It is with mixed feelings that I write this tribute to **Dr. E. Llewellyn-Thomas**, the first person to be recognized by our TABLEAU feature. I was greatly saddened by Dr. Llewellyn-Thomas' sudden death this summer and now appreciate the opportunity to pay tribute to this exceptional teacher, colleague and medical researcher.

"Tommy" was surely one of the most popular members of the Faculty. Over the ten years he was Associate Dean, he personally encouraged, counselled, cajoled and nudged 2,500 medical students to the completion of their undergraduate studies. He was their mentor, preceptor and role model – and a great deal more.

It was one of his proudest accomplishments that no student, otherwise qualified, had to drop out for financial reasons during his time in office; somehow and somewhere he always found money for student emergencies.

Dr. Llewellyn-Thomas was a man of many gifts. Coming to medicine from a background of service in the British Army, psychology and engineering, he continued to maintain a wide variety of interests throughout his life.

After a period of general medical practice, he entered a career of medical research in pharmacology and biomedical engineering. He was a Fellow of the Royal Society of Canada and held appointments in three Faculty of Medicine departments as well as the Faculty of Engineering.

Truly a Renaissance Man, Dr. Llewellyn-Thomas enjoyed a variety of sports, wrote poetry in his leisure hours and authored four published science fiction novels and a fifth which will appear next year. He was also founder and served as president of the Human Factors Association, a group dedicated to exploring human factors relating to machines and the environment.

Dr. Llewellyn-Thomas was a dedicated member of the Faculty; we will truly miss him.

Frederick H. Lowy
Dean

In honor Dr. Llewellyn-Thomas, a memorial fund has been established to sponsor the Llewellyn-Thomas Lectureship at the University. The inaugural lecture will be held in 1985. Further contributions will be welcome and should be made out to the University of Toronto — Llewellyn Thomas Fund and sent to Mrs. T. Smith-Fearman, Coordinator of Finance and Personnel, Faculty of Medicine.